Schertz-Cibolo-Universal City ISD Child Nutrition Department
Medical Statement Form
(To Provide Information for a School to Make an Appropriate Meal Accommodation)

PART A. Student, Parent/Guardian, and School Contact Information – To be completed by a parent/guardian or school contact person.

Incomplete forms cannot be processed and will be returned.

Student's Name:	Date of Birth:	School:
Parent/Guardian's Name:		ID #
Parent/Guardian's Email:		Cell Phone:
Please check meals student will eat: ☐ Breakfast ☐ Lunch		Please check if student has a: ☐ 504 ☐ IEP

PART B. Prescribed Diet Order – This part must be completed by a State Licensed Healthcare Professional

Check ONE:
☐ Student has a Disability/Impairment
☐ Student has other medical condition that does not rise to the level of a disability

1. Describe/explain the student's Disability/Impairment or medical condition:

2. What major life activities/major bodily functions are affected by the Disability/Impairment or medical condition?

☐Student has a prescribed Epi-Pen

3. How/why does this Disability/Impairment or medical condition restrict the student's diet?

4. Explain/describe the meal accommodation for the child's Disability/Impairment or medical condition:

5. Type of Special Diet:
☐ Student does not require a special diet
☐ Student requires a special diet. Please describe:
(i.e. low sodium, gluten-free, diabetic, etc.)

6. Foods to be Omitted and Substituted:
☐ Not Applicable

Dairy (Please specify)
☐ No Fluid Milk ☐ No Cheese ☐ No Yogurt
☐ No milk in ANY products (i.e. baked goods like bread, cookies) ☐Other:

☐ Milk Substitute Needed. Specify Type (lactose-free, soy, etc.): _____

Additional Information:

Eggs (Please specify)
☐ Whole eggs ☐ Eggs in foods (i.e. baked goods like bread, cookies)

Additional Information:

Other Allergens: ☐ Wheat ☐ Peanuts ☐ Tree Nuts ☐ Fish ☐ Shellfish ☐ Soy *
* Soy Allergy: Research states that *soy lecithin* and *soy oil* is well tolerated by persons with soy allergy. If student avoid these ingredients, please check here ☐

Other foods to be omitted: (please be as specific as possible)	Substitution:

7. **State Licensed Healthcare Professional Information** – Must be completed by student's health care provider. Please write clearly

Signature	Title:	
Printed Name:	Phone:	Date:

Part C. Parent/Guardian Permission – To be completed by a parent/guardian

I give permission for school personnel responsible for implementing my child's prescribed diet order to discuss my child's special dietary accommodations with any appropriate school staff and to follow the prescribed diet order for my child's school meals. I also give permission for my child's medical authority to further clarify the prescribed diet order on this form if requested to do so by school personnel.

Parent/Guardian's Signature: Date: